

“Ten-minute medicine” keeping them alive
until emergency medical services (EMS) arrive.

Treat him as best you can with common sense and do no harm.

Take two aspirin and call me in the morning.

—Conventional nonemergency advice

Medical Emergencies¹

A protection agent has many roles; among them are security specialist or protector, trip and logistics planner, confidant, friend, and emergency medical responder. So many things can befall a protectee that have nothing to do with the activities of terrorists, crazies, or anyone who would want to intentionally harm him. In spite of the very best preventive measures taken by a protection agent, accidents, injuries, and other life-threatening medical emergencies occur.

Every year, in just the United States, more than 100,000 people die from heart attacks, 1.5 million die from strokes, and more than 140,000 die from injuries.² More than 45,000 are killed in transport accidents. The number of homicides, poisonings, and drunk-driving fatalities are roughly the same, at around 17,000 each. Perhaps more surprisingly, a stunning 178,000 Americans die from medical or hospital error every year.³ Many of them die needlessly because of the lack of adequate and available emergency medical treatment. Many of those deaths can be prevented if certain procedures are immediately taken. Therefore, it is important that protection personnel have at least a minimum working knowledge of first aid. While it is not necessary for a protection agent to be a graduate of an emergency medical technician (EMT) course, it is very highly recommended.

The following material can in no way approximate the degree of training inclusive in EMT or advanced training and is intended to serve only as a very condensed version of emergency techniques and procedures that may provide a rescuer with the tools to save a life. It is intended only to introduce and acquaint the protection agent with some of the emergencies to expect that might be encountered in the course of his regular and routine duties. Proper preparation and response to an emergency could very well save a life. It is incumbent upon the protection agent to receive proper training in the skills necessary to professionally and adequately perform his job. Emergency medical response is a great part of that professionalism.

Whether at the White House, a hunting preserve in Texas, or a houseboat vacation on Lake Shasta in Northern California, in instances of injury or sudden illness, such as heart attack, stroke, or gunshot wound, everyone turns to the protection agent with expectations that he will be able to provide the necessary medical response until the emergency has been stabilized or the victim is in the care of professionals. The initial actions of those at the scene of the medical emergency could save the life of the victim.

Emergency medical response is sometimes referred to as “ten-minute medicine.” Lifesaving procedures such as cardiopulmonary resuscitation (CPR, or rescue breathing) and control of bleeding, if applied immediately, can sustain life beyond the absolute time limit of the 10 minutes it takes for a person to be considered brain dead and clinically dead.

Emergency medical services are those services (actions) that are required immediately when there is no time to wait for the arrival of an ambulance or medical technicians. Emergency medical treatment must be initiated as a result of unforeseen illness or injury. A first responder (the person or persons initially responding to the emergency) should meet certain goals and objectives:

- Promptly identify and respond to the emergency situation
- Use proper emergency medical care measures and life-support systems to sustain and prolong life
- Transport the victim to the nearest medical facility for more extensive care and treatment

Following an unexpected injury or illness is usually a time of total confusion, stress, and excitement. A protection agent or any person responding to the emergency must approach it in a calm, assured manner. His demeanor will be contagious to bystanders and the victim. If he appears confident and in charge, he will lend assurance to everyone, including the victim, that things will shortly be all right. Several things should be done at once and at the same time at the scene of the medical emergency:

Call 911. Before beginning any lifesaving procedures, it is recommended that the first person on the scene call 911 (or direct someone to make the call) to initiate professional emergency medical services such as a rescue squad or ambulance.

Provide safety. Make sure the victim is in a safe area to prevent further injuries to the victim, attending personnel, or even onlookers. If any electrical lines are down, they should be secured by qualified electrical workers. At the scene of an automobile accident, reroute or stop passing traffic. If there is gunfire, provide blocking barriers. If in a burning building or at the scene of a dangerous chemical spill, remove the victim to safer ground.

Handle with care. Win the victim’s confidence and alleviate some of his anxiety, especially in a heart attack or trauma victim. Speak softly and reassuringly. Minimize the degree of injury and convince him that he will soon be all right. A victim will be suffering great pain, accompanied by thoughts and fears of impending death. The psychological aspect of the victim must be considered of great importance. If he believes the injury or physical attack can be treated and he will be restored, having confidence in his rescuer, he will respond with a positive attitude that could forestall the onset of secondary trauma such as shock.

At times a gunshot victim has literally lost entire portions of his body and totally recovered. On the other hand is a victim suffering a small and easily treated

wound, say from a small-caliber gun like a .22, who believed he was dying and did in fact die. If a victim thinks to himself, Oh my God, I've been shot! I'm gonna die! he probably will unless he is mentally convinced that he will soon be OK. It is recommended not to approach the victim with, "Wow, you've been shot, just look at that hole! You could drive a truck through there! Shall I call anyone?...next of kin?... a priest?"

A returning Iran War veteran told of and described his wounds. As he was running toward the enemy, he was bayoneted in the upper abdomen and then shot as the attacker withdrew his bayonet. He ran a few steps before collapsing. When he woke up he was on a medical ship and being treated. He owes his life to rapid medical response and evacuation.

Assess the patient. Identify the victim's problems and establish which ones require immediate attention at the scene. This procedure is termed *patient assessment* or *primary survey*. The assessment is made by a process of physically examining the person of the victim. The primary survey is extremely important because it entails checking for and controlling immediate life-threatening problems such as a clogged airway, absence of breathing, stoppage of blood circulation, or loss of blood. The secondary assessment looks for other serious, but not immediately life-threatening injuries, such as broken bones or burns.

The patient assessment must be calm, unhurried, and systematic. Therefore, it is important to perform the assessment in a specific order so that no important information is missed. It begins at the top of the head, examining the right side and front middle and continues to the bottoms of the feet. The same procedure is followed on the left side and middle, then the back.

The patient assessment is divided into four steps:

1. Primary survey, including vital signs—breathing (respiration) and pulse
2. Resuscitation—restore breathing by CPR (chest compressions) if necessary
3. Secondary survey of patient
4. Provide needed emergency care

Obtain information. Finally, obtain information about the victim that may not be readily available later in the hospital (i.e., observations about the environment and what caused the injury, illness, or trauma). This information could be important to treating physicians. Include time of accident or onset of illness; any treatment that was given; condition and appearance of victim; and his pulse, respiration, and temperature when treatment was begun. It may be important to write the information on the face of the victim with a pen.

Primary Survey

A primary survey is an examination of the victim to locate and identify immediate, life-threatening conditions. Before moving the victim, ascertain if there is a possibility of a head, neck, or spinal area injury that could be exacerbated with movement. If an injury to the head, neck, or spine areas is suspected, do not move the victim until those areas have

been immobilized! The primary survey may have to be done in very awkward or uncomfortable positions, but nevertheless the following areas must be immediately examined, especially if the victim is not breathing, his skin is very pale, or his lips and fingernails are beginning to turn blue. Immediately check the ABCs:

- A—Airway
- B—Bleeding
- C—Circulation
- S—Shock

A—Airway. Is it open? If it is closed, what is causing the closure? Are blood, secretions, etc. threatening its state of remaining open? Gently tilt the head back and lift the chin (often this will be sufficient to open the airway). If tilting the head back does not open the airway, open the victim's mouth and look for debris that could be causing a blockage. Do not attempt to put a finger down the throat to remove a blockage, as this may only push the object further into the throat. In the event that head, neck, or spinal injuries are suspect, do not tilt the head. Is the victim breathing? What is the quality of respiration (rate, depth, regularity, and apparent normal ease)? To check breathing, look, listen, and feel for it. Look for the chest to rise and fall, place your ear near the victim's mouth and listen for breathing and feel for exhaled air. A victim may not be breathing yet you may see movement in the chest. Consequently the listening and feeling are important considerations in determining a victim's breathing.

B—Bleeding. Is there any major external hemorrhage? Does the patient appear to be in shock? Head wounds and cuts normally have a large amount of bleeding even if the wound is very small. It is not unusual, however, to have only minimal bleeding in the event of a gunshot, puncture, or knife wound unless a vein or artery is cut or a major organ is ruptured. Internal bleeding may very rapidly lead to symptoms of shock. During the primary survey, did you find the victim coughing up or vomiting blood? Is there swelling, bruises, hardness, or tenderness of the abdomen or other areas? Check for skull, chest, or stomach wounds (look in the back area also for entrance or exit wounds that could be missed in a frontal-only check).

C—Circulation. Does the patient have a pulse? What is the quality of the pulse (rate, regularity, strength)? Pulse is heartbeat. To determine the pulse, place two fingers (not a thumb) over the carotid artery (between the Adam's apple or voicebox area in the throat) and the main neck muscle and feel the beat. Look for the color of the lips and extremity nails (fingers and toes). If they remain pink and respond with color when pinched, they are receiving blood. But if they begin to turn blue, or do not return to the normal color after pinching, circulation has stopped.

S—Shock. Is the patient exhibiting signs and symptoms of shock or potential shock? Shock is characterized by a weak and irregular pulse; cold, clammy, pale, or bluish skin; rapid and shallow breathing; and confusion, anxiety, and/or loss of consciousness. If not treated immediately, shock is a major cause of death even in minor wounds. Shock is a very common secondary reaction to a traumatic injury such as a broken bone (especially a compound fracture when a victim can readily see the broken skin with the bone protruding and blood in the area). A victim may go into shock from hitting his thumb with a hammer. The pain may be so intense and coupled with a visual stimulus that the brain begins to shut down, causing the person to slip into shock. Shock can occur as a result

of a blow to the neurological system (the head, neck, or spinal area). Those areas must be carefully examined to prevent further injury. Are there any signs and/or symptoms that would cause one to suspect damage to the central nervous system? The circumstances of the injury are important when determining the possibility of head, neck, or back injuries. Is the person unconscious from a fall, accident, or blow to the head, neck, or spine? Are the head, neck, or spine in an abnormal position? Are there lumps or bruises on the head, eyes, or facial areas? Is there bleeding from the mouth, nose, or ears? Any headaches, nausea, and vomiting? Is vision blurred, speech slurred, or breathing difficult? Any dizziness, confusion, loss of balance, seizures, even loss of consciousness?

Secondary Survey

Begin at the head and check the victim all over for injuries that might be significant but may not be readily visible. Be sure to check front, back, and sides. Identify and correct any life-threatening problems. This assessment should be done rapidly but surely and confidently. The examining responder should be talking to the victim and reassuring him during the entire procedure. If he is conscious, the victim should be queried as to any locations of pain and discomfort. *Caution:* While making the assessment, do not fail to take whatever urgent treatment actions the circumstances dictate. For example, do not fail to maintain and clear an obstructed airway immediately. During the secondary survey, the victim may begin struggling for air or stop breathing, become unconscious, go into shock, or begin hemorrhaging. If this occurs, the appropriate emergency procedures must again be applied.

Provide Needed Emergency Care

After assessing the injuries to the victim, immediately begin emergency treatment, addressing the most serious injury or symptoms first.

Rescue Breathing Resuscitation

If a victim is not breathing after the airway is cleared, the rescuer (the protection agent) must restore breathing by cardiopulmonary resuscitation (CPR) and cardiac compression. A brain can be damaged after 3–5 minutes without blood and oxygen. The victim will be brain dead after 7 minutes and clinically dead after 10 minutes of not breathing and no circulation of blood (thus the term *10-minute medicine*, often used to describe the critical period when lifesaving procedures must be instituted). Although EMT training is not a requirement for an executive protection agent, CPR should be demanded!

To perform CPR (rescue breathing):

- Lay the victim flat on his back.
- Check for breathing.
- Open the airway. Open the mouth and check for obstructions. Tilt the head back and lift the chin.
- If the victim is still not breathing, begin rescue breathing.

American Red Cross CPR protocol promotes a mix of chest compressions and rescue breathing for victims who are unconscious and show no other signs of life.⁴

- Pinch the victim's nose shut and place your mouth over the victim's lips, causing a tight seal, and give two quick breaths, watching for the chest to rise. Repeat. Whenever possible, use a barrier device such as a resuscitation mask to protect against ingesting the victim's saliva or other liquid and to protect from infectious bacteria—but do not delay beginning rescue breathing to obtain a barrier device.
- Check for pulse with two fingers on the carotid artery.
- If there is no pulse, begin chest compressions. If there is a pulse, continue rescue breathing with one breath every four to five seconds.
- Check pulse after 12 breaths.
- To begin chest compressions, locate placement of rescuer's hands and compression point on the victim by placing two fingers in the notch where the breastbone meets the ribs. Place the other hand at the edge of the fingers on the head side of the victim. (The location should be approximately one inch above the breastbone notch.) Interlace your fingers of both hands and begin compressions.
- Press down, firmly forcing the breastbone to depress approximately 1.5–2 inches, then release, lifting only the finger part of the hands, leaving the heel of the hand in place on the breastbone. Administer 12–15 compressions at the count of “one, one thousand, two, one thousand, three...”
- Repeat rescue breathing of two breaths and 15 chest compressions at the rate of 2:15. If there are two rescuers, the rate of breathing and chest compressions should be 1:5.
- Check the pulse after every fourth cycle of breaths and compressions.
- Continue until the victim regains a pulse and is breathing on his own or until help arrives.

If there is a pulse but the victim is not breathing, perform rescue breathing at the rate of one breath every five seconds and check for breathing after every 12 breaths.

Monitor the victim until he is fully stabilized.

Control of Bleeding

If the bleeding is from an extremity (an arm or leg), elevate it and apply direct pressure over the wound. Use a clean cloth, gauze sponge, or terry cloth towel, if available, to apply pressure on the wound. If the cloth becomes saturated with blood, do not remove it. Simply apply a second cloth bandage over the first. If no cloth is available, apply pressure using your hand. If the wound has a projectile protruding from it or the wound is caused by a bullet, do not attempt to remove the object. Simply apply pressure around the object. Sometimes the skin must be pinched and held together.

If the wound is in the chest cavity area (front or back) or the abdomen, the blood being discharged may be pinkish and frothy. This is an indication that air is getting into the body through the wound and could cause an immediate breathing problem. That type of wound, a sucking chest wound, must be sealed airtight. Anything that will prevent air from seeping through can be used in an emergency to stop the inward airflow. A plastic

or rubberized cloth, a piece of aluminum foil, even the rescuer's hand must be placed over the wound to seal it off. Be sure to take the same precautions in the back area also.

If elevation and direct pressure fail to stop the bleeding, vital pressure points can be closed off by pressing on them. Pressure points are locations where arteries carrying blood from the heart can be squeezed to stop the blood. Locate a pressure point nearest to the wound between the heart and the wound and apply pressure until the blood flow is stopped. As a last resort, apply a tourniquet between the wound and the heart.

Tactical Combat Casualty Care^{®5}

Tourniquet Use Guidelines

Blood loss is the most common yet the most preventable cause of death resulting from gunshot or penetrating trauma.

The Facts

Tourniquets are a fast and successful tool to stop major extremity bleeding when used properly and with prior training. There are risks associated with any medical intervention done, but none outweigh the possibility of the loss of life due to extensive (arterial) bleeding.

Guidelines exist to aid in ensuring that responders use tourniquets correctly and lessen the chance of complications. None of the guidelines should be considered a substitute for professional instruction in the application of tourniquets. These guidelines are based on existing evidence, best practices, and military recommendations and experiences.

Tactical Combat Casualty Care[®] takes into account the differences in civilian populations and operating parameters in the guidelines and doesn't recommend or endorse a particular device. We recommend a commercially produced tourniquet as the first choice, as studies have shown that improvised tourniquets are ineffective in 40 percent of applications.

The best equipment you can use for any particular situation is the one that you have the most familiarity and training with. Having the best tourniquet in the world but not knowing how to use it does not increase the survivability of a patient. Understanding why you would use a tourniquet and when to use it are the most important aspects.

Proper placement of tourniquets depends on the operational situation facing the provider.

- **Hot zone**—In an active threat environment where there is imminent danger to the provider or patient, the tourniquet should be placed high on the extremity over the clothes.
- **Warm zone**—In an indirect threat environment or during non-high-threat situations, the tourniquet should be placed directly against the skin 3–4 inches above the wound but not over a joint. If the provider can't easily establish the extent of damage, the tourniquet should be placed high on the extremity.
- A proper tourniquet should result in not only visible control of bleeding but also the loss of a distal pulse in the extremity. If one tourniquet is not enough to control the bleeding, a second tourniquet should be added next to the first device.
- After proper placement of the tourniquet, the goal should be to transport the patient immediately to the nearest medical care facility. This greatly reduces the

chances of neurovascular damage to the extremity and dramatically increases quality-of-life issues for the patient's subsequent stabilization and recovery.

- Loosening the tourniquet in 15–20 minute intervals isn't recommended and doesn't reduce the chance of complications.

In all instances involving bleeding, after the bleeding is stopped and breathing and circulation are restored, treat the victim for shock.

Shock Treatment

Position the victim on his back with his feet elevated approximately 12 inches. Cover him to prevent chilling and make him comfortable. Do not administer liquid or food as this may cause vomiting and block the airway. Also do not position the head on a pillow, as this could also cause the airway to be blocked.

Anaphylactic shock is an extreme allergic reaction to an insect bite, a bee sting, or certain foods and drugs. It can be fatal if not immediately treated. The symptoms include the following:

- Skin irritation, itching, and possibly hives (a skin rash and possible swelling)
- Reddish and flushed face and warm skin
- Swollen face and/or tongue
- Dizziness and increased heart rate, difficulty breathing
- Nausea, vomiting, and/or stomach cramps
- Loss of consciousness

Treat the person in the same manner as regular shock. If available, apply medication specifically for allergic reactions. A shot or dosage of epinephrine may be administered. If it is suspected or known that a potential victim suffers from an allergic reaction, especially to insects and bees, it is prudent to have epinephrine (and proper instructions for administration) included in a medical kit. A commercial preparation called an Ana-Kit is available at the local pharmacy. However, it can be obtained only with a prescription. A protective agent should inquire if his protectee has any known allergies and if an epinephrine kit is readily available. This is a very severe allergic reaction and can result in death if not quickly treated.

Choking

The universal sign for choking is grabbing the throat area with two hands. Choking is usually caused by the ingestion of a large piece of food that has become stuck in the throat. Ask the victim if he can speak. If he can, he may be experiencing a heart attack that has some symptoms similar to choking. In the instance of a possible heart attack, the choking rescue should not be attempted as it will only increase the discomfort and risk.

If the victim's gag or cough reflex cannot dislodge the food item, he will be unable to breathe and will be experiencing fear and may begin to have bluish skin and bulging eyes. If treatment is not immediately begun to relieve the choking, he may become unconscious or have a seizure. The best method for dislodging the blockage is the Heimlich maneuver. This very simple maneuver can be quickly and easily accomplished with very little practice.

Simply stand close behind the victim and wrap your arms around him. Make a fist with one hand and place it in the middle of the abdomen, just above the navel and below the ribs. Clasp the fist with the other hand and give five quick, strong inward and upward thrusts. If that does not remove the blockage, repeat until the airway is open.

If the victim is unconscious or becomes unconscious and is not breathing, place him on his back and commence rescue breathing and, if necessary, chest compressions.

Heart Attack

If the victim can speak, cough, or make a noise through his mouth but is beginning to sweat; has shortness of breath or difficulty breathing; has pain radiating to the arm, neck, or jaw; has nausea or vomiting; and has dizziness and a rapid or irregular pulse, he may be experiencing a heart attack. Loosen any tight clothing and make the victim comfortable. Keep him warm with a blanket or extra clothing loosely placed over him. Monitor his breathing and pulse. If he stops breathing or his heart stops beating (pulse), begin CPR immediately. Speak to the victim in quiet, calm, and reassuring tones. Attempt to calm everyone else or have them leave the presence of the victim. Do not give him anything to eat or drink except any prescription medicine he may have or an aspirin to chew. Place him in a comfortable recovery position, with the victim on his stomach, one leg in a semicurved fold with the arm of the same side bent with the hand resting near the face. The opposite leg and arm are resting in a relaxed straight position.

A heart attack can be recognized by the following usual symptoms:

- Sudden crushing and squeezing pain in the chest or a tightness in breathing that lasts approximately 10 minutes or more. The pain often starts in the center of the chest and radiates to the jaw, neck, back, and arms, especially the left arm. The arm may begin to feel numb as though it were asleep.
- The heartbeat may become irregular or stop, with an accompanying shortness of breath and dizziness.
- Heavy sweating, beginning around the mouth area, nausea, and vomiting accompanied by fear and anxiety about dying.
- Loss of consciousness.

Stroke

A stroke is the result of blood to the brain being interrupted because of a blocked or pinched artery. It causes sudden weakness or numbness in the face, arm, or leg on one side of the body. The victim will experience sudden difficulty in seeing and may lose vision in (often) one eye. There will be an accompanying loss of speech or difficulty in speaking and he will have difficulty in understanding others. A severe headache will strike and cause dizziness and loss of balance and consciousness.

If the victim becomes unconscious and is not breathing, administer proper CPR. If he is breathing, place him in the recovery position and keep him warm. If he is conscious, make him comfortable in a reclining position with his head and shoulders slightly elevated, and offer him reassurance. Do not provide him with anything to eat or drink as

it could cause him to vomit and form a blockage in the airway. If he does begin to vomit, turn him onto his side to keep the airway open.

Heat Stroke and Heat Exhaustion

Heat stroke and heat exhaustion result from performing strenuous exercise in very hot or humid conditions. The body is deprived of its ability to cool itself and may stop sweating. There is a shortage of water in the body caused by excessive sweating and/or dehydration. These conditions are very common in long-distance runners, tennis players, and others who exercise very vigorously and refuse to admit a need to stop for refreshment.

Sometimes the conditions occur without the victim even feeling like he has been sweating. In a very dry climate, the sweat dries instantly, leaving the victim's clothing and skin dry, giving him the false sense that he is not losing water. These conditions can be avoided with proper hydration (taking liquid) before and during the activity. When thirst becomes evident, the dehydration process has already begun. In heat stroke (the most serious condition), the body's core temperature soars to 104 degrees or higher. The skin becomes hot and dry, and the pulse and breathing become labored and fast. Confusion, seizures, and loss of consciousness come on very quickly.

The body temperature must be lowered and restored as quickly as possible. Move the victim to a cooler environment and remove any clothing. Put cool, wet towels on his forehead, behind his neck and on his body. Place a cooling fan where it can blow over the victim and continue to sprinkle, splash or sponge cool water (never an alcohol rubdown) on the victim's skin. Do not give him food or drink until his temperature has stabilized.

Treatment for heat exhaustion is very similar. If the victim is conscious and can swallow without difficulty, administer a salt water drink in proportions of one teaspoon of salt in a quart of water; never give an alcohol or caffeine drink. Make victims of heat stroke and heat exhaustion comfortable and allow them rest. When they have sufficiently recovered, provide them with more liquid such as an electrolyte drink to replace the fluid and lost minerals.

Burns

If the victim is unconscious, is not breathing, and has no pulse, begin rescue breathing and CPR immediately. Remove clothing and jewelry from the burned area before swelling complicates the task and causes secondary problems. Burned arms and legs can be elevated to prevent or reduce any swelling. Keep the burned area clean and avoid breathing or coughing on it. If the burned area is small (6–8 inches diameter), loosely cover it with a cool, wet cloth or towel. If possible, let cool, running water run over the burn or hold it in a bowl of cool water for approximately 10 minutes or until the pain subsides.

For larger burns, place a light, clean, dry cloth or sheet over the burned area. If the cloth becomes soaked with fluid from the burn, place another cloth over it. If the victim remains conscious, he may be given small sips of water to avoid dehydration, but he should be monitored in the event he becomes unconscious or begins to vomit.

Do not apply ointments, butter, lotions, baking soda, ice, or any other matter that could infect the burned area. Do not attempt to wash the area with cotton balls or apply anything else such as adhesive bandages that will adhere to the burn. If blistering occurs, do not break the blisters.

There are four degrees of burns:

- **First Degree**—The most common. A searing of the top layer of skin. It is usually not serious but is most often very painful. Sunburn is a very common example of a first-degree burn. It is characterized as a reddening of the injured area.
- **Second Degree**—More serious and very painful. The burn injures the top two layers of skin and produces redness, swelling, and blistering. Some sunburns have risen to this degree.
- **Third Degree**—Initially are painless because the burn has extended through all layers of the skin and nerve endings. The burn area appears as charred or white skin.
- **Fourth Degree**—Extremely serious and life threatening. The burning extends through all layers of skin to the tissues and organs.

Hyperthermia

See Heat Stroke.

Hypothermia

Hypothermia is defined as a condition in which the human body is unable to maintain a core temperature of 95 degrees or above. People most likely susceptible to hypothermia under normal circumstances are diabetics, congenital heart failure victims, and alcoholics. Extended exposure to very low temperatures such as winter weather or icy water will cause an onset. If not treated, death will result.

Symptoms of hypothermia are as follows:

- Muscles become rigid
- Heartbeat slows and becomes irregular
- Drowsiness
- Difficulty speaking
- Unconsciousness

Treatment of hypothermia is as follows:

- Move victim to a warm area and remove wet clothing; replace clothing with warm dry clothing and blankets.
- Serve warm beverages (no caffeine—warm chicken broth or other neutral soup).
- If victim is not breathing, begin CPR.

The above-listed conditions are by no means all-inclusive of the medical emergencies that may be encountered by a protection agent. They are only some of the most common yet most serious that, if left untreated, could very easily result in the death of the victim. It is a personal responsibility of the protection agent to obtain training and instruction in providing emergency medical treatment and to be able to respond when a victim's life is dependent upon the agent's abilities. When in doubt, use good common sense, apply the ABCs, and do nothing that could cause further harm to the victim.

Medical Kit

It is not always possible to respond to a medical emergency with all the equipment necessary to treat every type of injury or illness. It is not expected that a lay person such as a protection agent will have access to some of the more specific equipment such as defibrillators, but the more common supplies should be readily on hand and available. A well-stocked emergency medical kit should include, as a minimum requirement, the following:

- Gauze bandages and rolls of gauze in all sizes, including Band-aids and very large, absorbent gauze sponges
- Rolls of adhesive tape and bandaging tape
- Large (sling size) triangular bandages
- Cold or instant ice packs (chemical packs)
- Tourniquet⁶
- Clean towels
- Space blanket (emergency thermal blanket)
- Nursing shears
- Assorted disinfectants, ointments, and pain relievers⁷
- Small flashlight
- A small roll of aluminum foil (good for sealing “sucking” chest wounds)
- Inflatable casts for broken arms legs
- Snake- and insect-bite kits (Ana-Kit)
- Emergency medical handbook
- Diarrhea medication⁸

Emergency medical care knowledge must be part of any protection specialist’s training and experience. Cardiopulmonary resuscitation and the knowledge and ability to restore breathing and control bleeding are lifesaving procedures. The immediate application of the ABCs of first aid is the difference between life and death.

Summary

- A—Check and open the *airway* (rescue breathing and CPR)
- B—Control and stop *bleeding* (direct pressure, pressure points, and tourniquet)
- C—Check and restore *circulation* (cardiac compression, CPR)
- S—Treat for *shock*

Review Questions

1. Explain, “Treat him with common sense and do no harm.”
2. Why is EMT training very highly recommended for a protection specialist?
3. Why is CPR training a requirement for a protection agent?
4. Explain the initial steps in responding to a medical emergency.
5. Why is the rescuer’s demeanor so important?
6. What are the ABCs of medicine? Describe the patient assessment.
7. Explain 10-minute medicine.

8. Explain rescue breathing.
9. When is CPR begun?
10. Explain the importance of an emergency medical kit to a protection agent and what it should contain.
11. Describe the proper use of a tourniquet.
12. How should a “sucking” chest wound be treated?
13. A protectee suffers a penetrating knife wound, with the knife still stuck in his chest. How should this be treated?

Endnotes

1. The information in this section is based on material taught in a standard EMT course.
2. <http://www.bing.com/search?q=how+many+people+die+from+heart+attacks%2C+strokes%2C+and+from+injuries+every+year+in+the+U.S.&qs=n&form=QBLH&pc=BNHP&pq=how+many+people+die+from+heart+attacks%2C+strokes%2C+and+from+injuries+every+year+in+the+u.s.&sc=0-0&sp=-1&sk=&cvid=7846e1b7635d4afe9ab4fa99b8a55b8a>, retrieved August 21, 2014.
3. http://wiki.answers.com/Q/How_many_people_die_in_the_US_every_year, retrieved August 21, 2014.
4. http://www.ehow.com/facts_6311341_red-cross-cpr-protocol.html, retrieved August 22, 2014.
5. Information regarding tourniquets provided by Raffaele Di Gregorio of Tactical Combat Casualty Care by email on September 14, 2014.
6. The first choice of the U.S. Army, the Army Surgeon General, and the Army Institute of Surgical Research, the Combat Application Tourniquet® (C-A-T®) is a small and lightweight one-handed tourniquet that completely occludes arterial blood flow in an extremity. The C-A-T® uses a self-adhering band and a friction adaptor buckle to fit a wide range of extremities combined with a one-handed windlass system. The windlass uses a free-moving internal band to provide true circumferential pressure to an extremity. The windlass is then locked in place; this requires only one hand, with the Windlass Clip™. The C-A-T® also has a hook-and-loop Windlass Strap™ for further securing of the windlass during patient transport. <http://combattourniquet.com/about/>, retrieved September 8, 2014.
7. With all medication, sprays, disinfectants, and ointments, keep away from children and be aware of the expiration date.
8. See note 7.

